

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-038276
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 817 Primary Registration District No. 541 Registrar's No. 3030

FILED OCT 10 1963

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Clayton</u>		c. CITY OR TOWN <u>Wellston</u>	
Length of stay in 1b <u>5 Days</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>County Hospt.</u>		d. STREET ADDRESS (If outside, give location) <u>6204 Suburban Ave.</u>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>T.</u> Last <u>FITZGERALD</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>29</u> Year <u>1963</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Marital Status <input checked="" type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-28-93</u>	9. AGE (last birthday) <u>70</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Factory</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ice Cream Co.</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>John Fitzgerald</u>		13b. MOTHER'S MAIDEN NAME <u>Margaret Murray</u>	
14. NAME OF HUSBAND OR WIFE <u>Cora Fitzgerald</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Cora Fitzgerald</u>		Address <u>6204 Suburban Ave.</u>			

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilat. Bronchopneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		
DUE TO (b) <u> </u>		
DUE TO (c) <u> </u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Asplenia Acute; Pancreatitis, Chronic</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u> </u>	
20c. TIME OF INJURY Hour <u> </u> Month <u> </u> Day <u> </u> Year <u> </u> a.m. <u> </u> p.m. <u> </u>			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u> </u>	20f. CITY; TOWN, OR LOCATION <u> </u>	COUNTY <u> </u> STATE <u> </u>

21. I attended the deceased from Sept. 24, 1963 to Sept. 29, 1963 and last saw him alive on Sept. 29, 1963
Death occurred at 10:30p m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>John M. Farmer</u>	(Degree or title) <u>M.D.</u>	22b. ADDRESS <u>601 S. Brentwood Bl., Clayton, Mo.</u>	22c. DATE SIGNED <u>9-30-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>10-2-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>

24. FUNERAL DIRECTOR <u>J.W. Clark</u>	ADDRESS <u>F.H. 1125 Hodiamont Ave.</u>	25. DATE RECD. BY LOCAL REG. <u>10-1-63</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy</u>
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USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300
Rev. 4/59

14002

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1245-0

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *W. W. Willebrand*

Licensed Embalmer No. 4511

P. O. Address St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.